



Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

**III. STATISTICAL DATA**

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	93	Skilled (SNF)		33,945	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS		33,945	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF	330	1,217	15,320	16,867	8
9	SNF/PED					9
10	ICF	2,418	6,391		8,809	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,748	7,608	15,320	25,676	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.64%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 8/14/99

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 8/14/99 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 93 and days of care provided 15,320

Medicare Intermediary Administar Federal

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	438,445	31,552	4,500	474,497	686	475,183		475,183		1
2	Food Purchase		236,354		236,354	(22,321)	214,033	(3,357)	210,676		2
3	Housekeeping	87,386	20,735		108,121	455	108,576		108,576		3
4	Laundry	40,134	10,065		50,199		50,199		50,199		4
5	Heat and Other Utilities			170,324	170,324		170,324	(1,390)	168,934		5
6	Maintenance	58,654		87,476	146,130		146,130	1,632	147,762		6
7	Other (specify):* security			9	9		9		9		7
8	<b>TOTAL General Services</b>	624,619	298,706	262,309	1,185,634	(21,180)	1,164,454	(3,115)	1,161,339		8
<b>B. Health Care and Programs</b>											
9	Medical Director			65,000	65,000		65,000		65,000		9
10	Nursing and Medical Records	1,513,802	156,708	8,072	1,678,582	3,744	1,682,326	(77,246)	1,605,080		10
10a	Therapy	88,896			88,896		88,896		88,896		10a
11	Activities	76,891	2,102	3,213	82,206		82,206		82,206		11
12	Social Services	42,047			42,047		42,047		42,047		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,721,636	158,810	76,285	1,956,731	3,744	1,960,475	(77,246)	1,883,229		16
<b>C. General Administration</b>											
17	Administrative	256,542			256,542		256,542	(36,851)	219,691		17
18	Directors Fees										18
19	Professional Services			593,217	593,217		593,217	(563,144)	30,073		19
20	Dues, Fees, Subscriptions & Promotions			48,639	48,639		48,639	(44,388)	4,251		20
21	Clerical & General Office Expenses	386,899	19,865	123,512	530,276	38	530,314	22,680	552,994		21
22	Employee Benefits & Payroll Taxes			395,636	395,636	17,398	413,034	24,294	437,328		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,707	1,707		1,707	5,407	7,114		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			60,027	60,027		60,027	8,770	68,797		26
27	Other (specify):* Bad Debt			82,919	82,919		82,919	(82,919)			27
28	<b>TOTAL General Administration</b>	643,441	19,865	1,305,657	1,968,963	17,436	1,986,399	(666,151)	1,320,248		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,989,696	477,381	1,644,251	5,111,328		5,111,328	(746,512)	4,364,816		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Alden North Shore Rehab &amp; HCC

#0042028

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			53,433	53,433		53,433	210,825	264,258			30
31	Amortization of Pre-Op. & Org.			2,259	2,259		2,259	957	3,216			31
32	Interest			273,592	273,592		273,592	482,030	755,622			32
33	Real Estate Taxes							256,739	256,739			33
34	Rent-Facility & Grounds			1,067,974	1,067,974		1,067,974	(1,067,974)				34
35	Rent-Equipment & Vehicles			10,453	10,453		10,453	9,966	20,419			35
36	Other (specify):* <b>mort insurance</b>							60,841	60,841			36
37	<b>TOTAL Ownership</b>			1,407,711	1,407,711		1,407,711	(46,616)	1,361,095			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		706,886	1,051,121	1,758,007		1,758,007	(29,158)	1,728,849			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,918	50,918		50,918		50,918			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		706,886	1,102,039	1,808,925		1,808,925	(29,158)	1,779,767			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,989,696	1,184,267	4,154,001	8,327,964		8,327,964	(822,286)	7,505,678			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(58,376)	30		9
10	Interest and Other Investment Income	(631)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,931)	2		13
14	Non-Care Related Interest	(27,327)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(42)	21		17
18	Fines and Penalties				18
19	Entertainment	(1,920)	20		19
20	Contributions	(3,624)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,221)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,919)	27		24
25	Fund Raising, Advertising and Promotional	(37,575)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (220,566)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(417,310)	Various	34
35	Other- Attach Schedule	(184,410)	PG 5a	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (601,720)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (822,286)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## Alden North Shore Rehab &amp; HCC

ID# 0042028

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	valet cost	\$ (39,667)	21	1
2	late fee on telephone	(3,001)	5	2
3				3
4	intercompany interest gl 7031 ( FAS)	(95,580)	32	4
5				5
6	intercompany interest gl 7053	(1,646)	32	6
7	Misc Inc. - Insurance settlement - R&M (4977)	(2,945)	6	7
8	Misc Inc. - Resident Interest (4977)	(411)	32	8
9	gain on asset sale gl 4983-4985	81	6	9
10	Backout prior yr vend. Settlement costs (maint.)	1,917	6	10
11	RC f21 t6 - misc vend sett.	(1,917)	6	11
12	RC f21 t6 - misc vend sett.	1,917	21	12
13	Back out 30.13% of IHCA dues	(1,513)	20	13
14	Record additional Def maint exp to correct amt	362	6	14
15	Back out prior yr Schmidt, Salzm. Credit	304	19	15
16	Adj dep to actual	(2)	30	16
17	Back out J. Jacobs salary on line 17 (marketing)	(36,851)	17	17
18	Marketing Employ.Benefits Deduction	(5,458)	22	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(184,410)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,931)	0	0	(1,426)	0	0	0	0	0	0	0	(3,357)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,001)	0	1,611	0	0	0	0	0	0	0	0	(1,390)	5
6	Maintenance	(2,502)	0	5,231	0	0	0	(51)	(1,046)	0	0	0	1,632	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(7,434)</b>	<b>0</b>	<b>6,842</b>	<b>(1,426)</b>	<b>0</b>	<b>0</b>	<b>(51)</b>	<b>(1,046)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,115)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(76,792)	(454)	0	0	0	0	0	0	(77,246)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(76,792)</b>	<b>(454)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(77,246)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(36,851)	0	0	0	0	0	0	0	0	0	0	(36,851)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,917)	5,667	(562,894)	0	0	0	0	0	0	0	0	(563,144)	19
20	Fees, Subscriptions & Promotions	(44,632)	0	244	0	0	0	0	0	0	0	0	(44,388)	20
21	Clerical & General Office Expenses	(37,792)	0	14,361	28,233	17,878	0	0	0	0	0	0	22,680	21
22	Employee Benefits & Payroll Taxes	(5,458)	0	25,677	0	4,075	0	0	0	0	0	0	24,294	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,407	0	0	0	0	0	0	0	0	5,407	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	8,645	125	0	0	0	0	0	0	0	0	8,770	26
27	Other (specify):*	(82,919)	0	0	0	0	0	0	0	0	0	0	(82,919)	27
28	<b>TOTAL General Administration</b>	<b>(213,569)</b>	<b>14,312</b>	<b>(517,080)</b>	<b>28,233</b>	<b>21,953</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(666,151)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(221,003)</b>	<b>14,312</b>	<b>(510,238)</b>	<b>(49,985)</b>	<b>21,499</b>	<b>0</b>	<b>(51)</b>	<b>(1,046)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(746,512)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(58,378)	256,798	10,584	0	1,821	0	0	0	0	0	0	210,825 30
31	Amortization of Pre-Op. & Org.	0	0	727	0	0	230	0	0	0	0	0	957 31
32	Interest	(125,595)	584,149	21,489	0	1,639	348	0	0	0	0	0	482,030 32
33	Real Estate Taxes	0	253,037	3,020	0	682	0	0	0	0	0	0	256,739 33
34	Rent-Facility & Grounds	0	(1,067,974)	0	0	0	0	0	0	0	0	0	(1,067,974) 34
35	Rent-Equipment & Vehicles	0	0	9,966	0	0	0	0	0	0	0	0	9,966 35
36	Other (specify):*	0	60,841	0	0	0	0	0	0	0	0	0	60,841 36
37	<b>TOTAL Ownership</b>	<b>(183,973)</b>	<b>86,851</b>	<b>45,786</b>	<b>0</b>	<b>4,142</b>	<b>578</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46,616) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(59,767)	(77,333)	107,942	0	0	0	0	0	(29,158) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(59,767)</b>	<b>(77,333)</b>	<b>107,942</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,158) 44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(404,976)</b>	<b>101,163</b>	<b>(464,452)</b>	<b>(109,752)</b>	<b>(51,692)</b>	<b>108,520</b>	<b>(51)</b>	<b>(1,046)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(822,286) 45</b>

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See pg 6k		See pg 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Lease revenue	\$ 1,067,974		100.00%	\$	\$ (1,067,974)
2	V	32 Investment interest	141,908				(141,908)
3	V	19 Audit				3,800	3,800
4	V	19 Misc admin fees				1,407	1,407
5	V	33 real estate taxes				253,037	253,037
6	V	26 insurance expense				8,645	8,645
7	V	32 interest on mortgage payable				726,057	726,057
8	V	36 mortgage insurance premium				60,841	60,841
9	V	30 depreciaton				256,798	256,798
10	V	19 Misc. expense				460	460
11	V						
12	V						
13	V						
14	Total		\$ 1,209,882			\$ 1,311,045	\$ * 101,163

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22	employee benefits	\$		\$ 25,677	\$ 25,677
16	V	19	professional fees	570,043		7,149	(562,894)
17	V	21	gen'l & admin			14,361	14,361
18	V	5	utilities			1,611	1,611
19	V	6	maintenance			5,231	5,231
20	V	24	travel & seminar			5,407	5,407
21	V	26	insurance			125	125
22	V	20	dues & subscriptions			244	244
23	V	30	depreciation			10,584	10,584
24	V	31	amortization			727	727
25	V	33	real estate tax			3,020	3,020
26	V	35	rent-equipment & vehicles			9,966	9,966
27	V	32	interest			21,489	21,489
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 570,043			\$ 105,591	\$ * (464,452)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 tube-feeding	\$ 9,527	Pyramid Health Care	100.00%	\$ 8,101	\$ (1,426)
16	V	10 nursing supplies	80,260	Pyramid Health Care		3,468	(76,792)
17	V	39 per diems/other supplies	129,928	Pyramid Health Care		70,161	(59,767)
18	V	21 gen'l & admin		Pyramid Health Care		28,233	28,233
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 219,715			\$ 109,963	\$ * (109,752)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 266,612	Forum Extended Care II	100.00%	\$ 225,236	\$ (41,376)
16	V	10 house stock	2,926	Forum Extended Care II		2,472	(454)
17	V	39 I.V.	231,698	Forum Extended Care II		195,741	(35,957)
18	V	22 employee benefits		Forum Extended Care II		4,075	4,075
19	V	21 gen'l & admin		Forum Extended Care II		17,878	17,878
20	V	32 interest		Forum Extended Care II		1,639	1,639
21	V	33 real estate tax		Forum Extended Care II		682	682
22	V	30 depreciaton		Forum Extended Care II		1,821	1,821
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 501,236			\$ 449,544	\$ * (51,692)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 therapy	\$ 1,018,089	Community Physical Therapy	100.00%	\$ 1,126,031	\$ 107,942
16	V	32 interest		Community Physical Therapy		348	348
17	V	31 amortization		Community Physical Therapy		230	230
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,018,089			\$ 1,126,609	\$ * 108,520

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	
15	V	6 repairs and maintenance	\$ 15,931	Alden Bennett Construction		\$ 15,880	\$ (51)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 15,931			\$ 15,880	\$ * (51)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 CARPET CLEANING	\$ 12,153	ALDEN REALTY - CARPET CARE		\$ 11,309	\$ (844)
16	V	6 FLOOR CLEANING	3,552	ALDEN REALTY - FLOOR CARE		3,350	(202)
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 15,705			\$ 14,659	\$ * (1,046)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Facility Name & ID Number ALDEN NURSING CENTER - NORTH SHORE

# 004-2028

Report Period Beginning 01/01/03

Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingtondale
Alden of Old Town West	Bloomingtondale
Alden Trails	Bloomingtondale
ANC Waterford	Aurora
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governer's Park of Barrington	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive	22.00	338,179	0.968	2.42	Salary	\$ 8,373	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	1.67	84,961	0.968	2.42	Salary	2,104	10-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	82,160	0.968	2.42	Salary	2,034	6-1	3
4	Joan Carl d.	Secretary	Vice-President	7.50	212,865	0.968	2.42	Salary	5,270	17-1	4
5	see others attached on page 7A			2.00	603,053				14,931		5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 32,712		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

1	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1								\$		1	
2	Summary...										
3	Ami Pissetzki	finance relations	invest/bank	1.00	191,625	0.968	2.42	Salary	4,744	17-1	3
4	Bob Molitor	Vp of Operations	operations	0.50	212,916	0.968	2.42	Salary	5,272	17-1	4
5	Mary Chelotti Smith	In-house counsel	legal advis.	0.50	198,512	0.968	2.42	Salary	4,915	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 14,931		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Alden Management Servcies, Inc  
 Street Address 4200 W. Peterson Ave.  
 City / State / Zip Code Chicago, IL 606046  
 Phone Number ( 773) 286-3883  
 Fax Number ( 773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">see pg 8A (also on pg 6A)</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Alden North Shore Rehab & HCC # 0042028 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		8	9	10										
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Prudential		X	Mortgage	\$53,349.00	3/1/98	\$ 8,388,000	\$ 8,208,405	9/30/39	7.2000	\$ 592,586	1								
2	Cambridge		X	Oper Loss Loan	\$16,822.00	4/1/03	3,098,700	3,081,386	8/31/39	5.6900	133,471	2								
3												3								
4												4								
5	Leumi interest		X	operations	Interest	6/1/02	620,000	Paid off	3/31/04	4.8000	7,130	5								
	<b>Working Capital</b>																			
6	related party-Ams	X		working capital							21,489	6								
7	related party-CPT	X		working capital							348	7								
8	related party-FECH	X		working capital							1,639	8								
9	TOTAL Facility Related				\$70,171.00		\$ 12,106,700	\$ 11,289,791			\$ 756,663	9								
	<b>B. Non-Facility Related*</b>																			
10	offset interest expense with NS Assoc's interest income										(631)	10								
11	offset interest expense with Corp's interest income										(411)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (1,042)	14								
15	TOTALS (line 9+line14)						\$ 12,106,700	\$ 11,289,791			\$ 755,622	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 60,841 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2002 report.			\$	133,200	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	190,237	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	57,037	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	196,000	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	253,037	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	11,976	8		
		1999	67,899	9		
		2000	130,432	10		
		2001	129,328	11		
		2002	190,237	12		
<b>Accrual based on 3% increase over prior year bill.</b>						
				<b>FOR OHF USE ONLY</b>		
		13	FROM R. E. TAX STATEMENT FOR 2002	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-28-429-015-0000</u>	<u>Nursing home facility</u>	\$ <u>2,478.79</u>	\$ <u>2,478.79</u>
2. <u>10-28-429-016-0000</u>	<u>Nursing home facility</u>	\$ <u>1,775.58</u>	\$ <u>1,775.58</u>
3. <u>10-28-429-017-0000</u>	<u>Nursing home facility</u>	\$ <u>5,096.42</u>	\$ <u>5,096.42</u>
4. <u>10-28-429-018-0000</u>	<u>Nursing home facility</u>	\$ <u>18,543.91</u>	\$ <u>18,543.91</u>
5. <u>10-28-429-019-0000</u>	<u>Nursing home facility</u>	\$ <u>18,553.28</u>	\$ <u>18,553.28</u>
6. <u>10-28-429-020-0000</u>	<u>Nursing home facility</u>	\$ <u>18,420.23</u>	\$ <u>18,420.23</u>
7. <u>10-28-429-021-0000</u>	<u>Nursing home facility</u>	\$ <u>18,420.23</u>	\$ <u>18,420.23</u>
8. <u>10-28-429-022-0000</u>	<u>Nursing home facility</u>	\$ <u>18,403.95</u>	\$ <u>18,403.95</u>
9. <u>10-28-429-023-0000</u>	<u>Nursing home facility</u>	\$ <u>18,387.23</u>	\$ <u>18,387.23</u>
10. <u>10-28-429-024-0000</u>	<u>Nursing home facility</u>	\$ <u>18,373.17</u>	\$ <u>18,373.17</u>
	<b>TOTALS</b>	\$ <u>138,452.79</u>	\$ <u>138,452.79</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden North Shore Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042028

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>10-28-429-025-0000</u>	<u>Nursing home facility</u>	\$ <u>18,373.17</u>	\$ <u>18,373.17</u>
2. <u>10-28-429-026-0000</u>	<u>Nursing home facility</u>	\$ <u>18,373.17</u>	\$ <u>18,373.17</u>
3. <u>10-28-429-027-0000</u>	<u>Nursing home facility</u>	\$ <u>15,028.72</u>	\$ <u>15,028.72</u>
4. _____	<u>Related Party - Alden Management</u>	\$ <u>125,008.00</u>	\$ <u>3,020.00</u>
5. _____	<u>Related Party - Forum</u>	\$ <u>8,317.00</u>	\$ <u>682.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>185,100.06</u>	\$ <u>55,477.06</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028 Report Period Beginning:

01/01/2003 Ending:

12/31/2003

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,208 B. General Construction Type: Exterior brick Frame steel Number of Stories 2C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF	34,483	1997	\$ 955,797	1
2					2
3	TOTALS	34,483		\$ 955,797	3

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Related party-Forum		1978	\$ 15,909	\$	22	\$	\$	\$ 15,909	4
5										5
6	93	1999	1999	6,782,967	195,977	40	169,574	(26,403)	678,296	6
7										7
8										8
	<b>Improvement Type**</b>									
9	draper corp-electric screen		1999	1,252	125	10	125		543	9
10	dakota wiring & comm.-wiring for cable tv		1999	2,500	250	10	250		1,063	10
11	climate serv-repair compressor		1999	1,990	133	15	133		542	11
12	tcj cable-install cable		1999	1,254	125	10	125		523	12
13	ABC-install tiles/repair		2000	4,011	267	15	267		1,025	13
14	ABC-mainten-various/construction		2000	5,000	500	10	500		1,917	14
15	ABC-mainten-various/construction		2000	10,000	1,000	10	1,000		3,750	15
16	ABC-mainten-various/construction		2000	10,000	1,000	10	1,000		3,667	16
17	new horizons-phone system		2000	5,744	574	10	574		2,154	17
18	new horizons-phone system & cable		2000	2,784	278	10	278		1,021	18
19	new horizons-phone system		2000	3,742	374	10	374		1,372	19
20	dbb contract-lawn sprinkler system		2000	1,611	107	15	107		376	20
21	ABC-misc construction work		2000	5,347	1,070	5	1,070		3,387	21
22	ABC-misc construction work		2000	13,118	2,624	5	2,624		8,089	22
23	ABC-misc construction work (12/31/01 finished-begin exp '02)		2001	3,361	336	10	336		672	23
24	Laport (walk off mat carpet/floor covering)		2001	3,548	710	5	710		1,537	24
25	The Floor Source (PT carpet/floor covering)		2001	1,576	315	5	315		657	25
26	ABC-beds/bedside cabinets/washers/dryers/bookcases/wallcover		2001	289,721	19,315	15	19,315		57,944	26
27	New Horizon (phone system)		2001	1,256	126	10	126		272	27
28	ABC-misc construction work		2002	19,580	1,305	15	1,305		2,611	28
29	ABC-misc construction work		2002	6,706	447	15	447		894	29
30	ABC-misc construction work		2002	16,368	1,091	15	1,091		2,182	30
31	ABC-misc construction work		2003	2,116	212	10	212		212	31
32	GT Mechanical-repair exhaust fans		2003	6,080	405	10	405		405	32
33	EWS-repair opxyen alarm ssystem		2003	2,054	206	5	206		205	33
34	ABC-parking lot upgrades		2003	7,538	377	10	377		377	34
35	ABC-parking lot repairs		2003	2,943	294	5	294		294	35
36										36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning:

01/01/2003 Ending: 12/31/2003

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12D, Carried Forward</b>	\$ 7,230,075	\$ 229,543		\$ 203,140	\$ (26,403)	\$ 791,896		1
2									2
3	<b>Related Party-Forum:</b>								3
4	Leasehold Improvement-Remodeling	1980 16,755		20			16,755		4
5	Leasehold Improvement-Remodeling	1980 1,047		10			1,047		5
6	Leasehold Improvement-Remodeling	1986 559		5			559		6
7	Leasehold Improvement-Remodeling	1990 350		5			350		7
8	Leasehold Improvement-Remodeling	1991 82		5			82		8
9	Leasehold Improvement-Remodeling	1993 7,732		10			7,732		9
10	Leasehold Improvement-Remodeling	1993 6,056		9.7			6,056		10
11	Leasehold Improvement-sign	1994 226	14	12	14		120		11
12	Leasehold Improvement-dryvit	1995 384	24	10	24		203		12
13	Leasehold Improvement-new ac	1999 626	39	15	39		203		13
14	Leasehold Improvement-roof	1985 843	44	19	44		843		14
15	Leasehold Improvement-roof	1994 748	47	15	47		529		15
16	Leasehold Improvement-roof	1997 710	44	15	44		349		16
17	Leasehold Improvement-roof	1998 1,205	75	15	75		507		17
18	Leasehold Improvement-parking lot asphalt	2000 96	32	10	32		63		18
19	Leasehold Improvement-hallway lighting	2001 135	27	10	27		56		19
20	Leasehold Improvement-DAI	2001 169	17	10	17		53		20
21	Leasehold Improvement-bathrooms	2002 630	63	10	63		80		21
22	Leasehold Improvement-Remodeling	2002 91	18	5	18		36		22
23	Leasehold Improvements-Remodeling	2003 1,638	164	10	164		164		23
24	Leasehold Improvements-Remodeling	2003 105	4	4	4		4		24
25									25
26	<b>Related Party-AMS:</b>								26
27	Leasehold Improvement-Remodeling	1993 6,132		7			6,132		27
28	Leasehold Improvement-Remodeling	2002 5,020	627	7	627		4,392		28
29	Leasehold Improvement-Remodeling	2003 5,251	660	7	660		4,611		29
30									30
31									31
32									32
33	<b>Forum Extended Care, LLC-building/building improv</b>	1999 15,137	378	40	378		1,896		33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 7,301,802	\$ 231,820		\$ 205,417	\$ (26,403)	\$ 844,718		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 589,384	\$ 76,117	\$ 44,144	\$ (31,972)	Various	\$ 286,947	71
72	Current Year Purchases	18,568	1,582	1,582		Various	1,582	72
73	Fully Depreciated Assets	40,851	1,098	1,098		Various	40,851	73
74								74
75	TOTALS	\$ 648,803	\$ 78,797	\$ 46,824	\$ (31,972)		\$ 329,380	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	98-'03	\$ 11,860	\$ 2,052	\$ 2,052	\$	3	\$ 11,658	76
77	bus-van	01 bus	01	49,826	9,965	9,965		5	29,896	77
78										78
79										79
80	TOTALS			\$ 61,686	\$ 12,017	\$ 12,017	\$		\$ 41,554	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,968,088	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 322,634	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 264,258	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (58,376)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,215,652	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Related party - cost is backed out  
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO  
 If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning 3/1/00  
 Ending 12/31/2039

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2004</u>	\$ <u>791,604</u>
13.	<u>/2005</u>	\$ <u>791,604</u>
14.	<u>/2006</u>	\$ <u>791,604</u>

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
 by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ 10,453 Description: Copy machine lease, \$10,193 and postage meter rental \$260  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Various</u>	<u>Various</u>	\$ <u>830.50</u>	\$ <u>9,966</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>830.50</b>	\$ <b>9,966</b>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled nurses on site</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 358,224	\$		\$ 358,224	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			48,280			48,280	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			611,584			611,584	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See pg 16A	# of prescripts				190,727		190,727	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	See pg 16A					520,034		520,034	13
14	TOTAL			\$		\$ 1,018,088	\$ 710,761		\$ 1,728,849	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 49,640	\$ 73,799	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 116,765 )	1,183,192	1,183,192	3
4 Supply Inventory (priced at )	659	659	4
5 Short-Term Investments			5
6 Prepaid Insurance	4,142	48,693	6
7 Other Prepaid Expenses	1,592	1,592	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Due from 3rd parties	(45,365)	(45,365)	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,193,860	\$ 1,262,570	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		955,797	13
14 Buildings, at Historical Cost		7,839,086	14
15 Leasehold Improvements, at Historical Cost	435,666	435,666	15
16 Equipment, at Historical Cost	140,336	1,052,643	16
17 Accumulated Depreciation (book methods)	(160,906)	(1,272,828)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	98,700	237,937	19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(2,258)	(45,053)	20
21 Restricted Funds		371,198	21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 511,538	\$ 9,574,446	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,705,398	\$ 10,837,016	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 2,145,852	\$ 2,145,852	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	58,385	58,385	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	221,819	221,819	30
31 Accrued Taxes Payable (excluding real estate taxes)	12,235	12,235	31
32 Accrued Real Estate Taxes(Sch.IX-B)		196,000	32
33 Accrued Interest Payable		63,861	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 accrued ins,exps,idpa,sales tax,etc.	49,886	49,886	36
37 Due to affiliates	545,986	434,229	37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,034,163	\$ 3,182,267	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	3,081,386		39
40 Mortgage Payable		11,289,791	40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44 <b>Deferred Financing Costs</b>		96,441	44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,081,386	\$ 11,386,232	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,115,549	\$ 14,568,499	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,410,151)	\$ (3,731,483)	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,705,398	\$ 10,837,016	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,066,432)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,066,432)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(343,719)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (343,719)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,410,151)	24 *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,456,511	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,456,511	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	143,840	6
7	Oxygen	1,163	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 145,003	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,836	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,613	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	605	19
20	Radiology and X-Ray		20
21	Other Medical Services	12,497	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 24,551	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	631	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 631	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Page 19A</u>	3,274	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,274	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,629,970	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,185,634	31
32	Health Care	1,956,731	32
33	General Administration	1,968,963	33
<b>B. Capital Expense</b>			
34	Ownership	1,407,711	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,758,007	35
36	Provider Participation Fee	50,918	36
<b>D. Other Expenses (specify):</b>			
37	<u>Related Party</u>	(354,275)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,973,689	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(343,719)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (343,719)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,976	2,104	\$ 71,426	\$ 33.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,483	23,371	641,446	27.45	3
4	Licensed Practical Nurses	6,922	7,112	158,538	22.29	4
5	Nurse Aides & Orderlies	45,354	46,954	565,956	12.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,026	2,122	26,291	12.39	8
9	Activity Director	2,000	2,080	36,010	17.31	9
10	Activity Assistants	4,453	4,568	40,884	8.95	10
11	Social Service Workers	1,968	2,080	42,047	20.21	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,093	49,527	23.66	13
14	Head Cook	5,395	6,050	74,743	12.35	14
15	Cook Helpers/Assistants	28,601	30,498	311,746	10.22	15
16	Dishwashers					16
17	Maintenance Workers	1,947	2,126	48,715	22.91	17
18	Housekeepers	9,593	10,234	83,753	8.18	18
19	Laundry	4,635	4,997	40,134	8.03	19
20	Administrator	1,976	2,080	79,756	38.34	20
21	Assistant Administrator					21
22	Other Administrative	5,125	5,537	147,339	26.61	22
23	Office Manager					23
24	Clerical	4,837	5,112	57,198	11.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,002	1,018	29,595	29.07	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CSS & Ward Cler	3,957	4,165	94,338	22.65	32
33	Other(specify) <u>Volunteer Coor.</u>	1,530	1,560	35,979	23.06	33
34	TOTAL (lines 1 - 33)	157,817	165,861	\$ 2,635,421 *	\$ 15.89	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	375/mo	\$ 4,500	1-3	35
36	Medical Director	5417/mo	65,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	186/mo	2,232	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	2,196	11-3	44
45	Social Service Consultant	19	1,018	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	60	\$ 74,946		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ N/A		50
51	Licensed Practical Nurses			51
52	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number Alden North Shore Rehab & HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Description	Amount		
Carrie DiPaolo	Administrator	0	\$ 142,796	Workers' Compensation Insurance	\$ 93,709	IDPH License Fee	\$	Advertising: Employee Recruitment			
A. Foutris	executive mgmt		42,905	Unemployment Compensation Insurance	26,230	Health Care Worker Background Check	189	(Indicate # of checks performed 27)			
				FICA Taxes	196,082	Surety bond fees, dues & subscriptions	312	IL Health Care Assoc	3,506		
				Employee Health Insurance	68,019	Employee Assoc. Due					
				Employee Meals	22,321						
Executive / Management	Executive Mgmt		33,990	Illinois Municipal Retirement Fund (IMRF)*							
				dental, life, pension costs	2,016						
TOTAL (agree to Schedule V, line 17, col. 1)				relations,miscell, & background chks	1,266						
(List each licensed administrator separately.)			\$ 219,691	drug test, 401k match, vaccinations	3,391						
B. Administrative - Other				Marketing Employ. Benefits Deduction				Related Party - AMS			
Description				Amount				Less: Public Relations Expense ( )			
								Non-allowable advertising ( )			
								Yellow page advertising ( )			
								TOTAL (agree to Sch. V, line 20, col. 8) \$ 4,251			
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V, line 22, col.8)							
(Attach a copy of any management service agreement)				\$ 437,328							
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #		Amount	Description	Amount		
Alden Management Services	MNGT. FEES		\$ 570,043				\$	Out-of-State Travel	\$		
BDO	ACCT. FEES		6,066								
Fisch / Hermon / Greenburg	Legal Fees		11,330								
AMS	Legal Fees		1,000					In-State Travel			
Medicom	Billing consultants		182					misc/gas/repairs	832		
Talx Corp	unemployment consult.		220								
Career Advancement Cons	Recruting service		4,000					Related Party - AMS	5,407		
Monster.com	Recruting service		413					Seminar Expense			
Jennings Law / Dana Consulting	401k Services		267					IL Healthcare Assoc.	225		
Schmidt Salzman & Moran Cr	real est appeal prior yr		(304)					American Exp - MDS Training	120		
								SANITA/CERTIFICATE & G-Tube Trainin	530		
								Entertainment Expense ( )			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	\$ 7,114		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 593,217								

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
													Improvement Type
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	painting>\$1500 for 2000	7/00	\$ 2,176	3	\$ 363	\$ 725	\$ 725	\$ 363	\$ 0	\$	\$	\$	\$
2	GT Mechanical-repair hot	10/03	2,258	3				188	753	753	564	0	0
3	ABC-repair water booster	6/03	2,209	3				429	736	736	308	0	0
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 6,643		\$ 363	\$ 725	\$ 725	\$ 980	\$ 1,489	\$ 1,489	\$ 872	\$	\$

Facility Name &amp; ID Number Alden North Shore Rehab &amp; HCC

# 0042028

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Health Care Assoc, \$5,021.50
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,900 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 50,918  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,321 Has any meal income been offset against related costs? None Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. not required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - NorthShore  
 Reporting Period Beginning  
 Reporting Period Ending

# 004-2028  
 1/01/03  
 12/31/03

Page 25

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(22,321)	Employee Meal
	22	22,321	Employee Meal
22		(4,923)	Uniforms
	10	3,744	Uniforms
	6	0	Uniforms
	4	0	Uniforms
	1	686	Uniforms
	3	455	Uniforms
	11	0	Uniforms
	21	38	Uniforms
19			R/E Tax Appeal
	33		R/E Tax Appeal
		<u>(0)</u>	Net should be 0